At the 1993 National Gay and Lesbian Health Conference in Houston, California psychologist Walt Odets questioned the very essence of HIV prevention efforts. While I do not want to go as far as he did, I find myself in sympathy with much of what he said. It seems to me that we are probably deluding ourselves about our HIV education efforts for gay men and that the result is a level of complacency that could prove very costly.

Contrary to what we would like to believe, for many gay men there is not a "safe sex" culture. In fact, the incidence of unsafe behavior remains disturbingly high. This raises questions about the effectiveness of our current approach to behavior change interventions. This article uses several Australian studies to define the limits of our presumptions about the "safe sex culture" and to outline alternative interventions that might extend beyond these limits.

The Failure of Safe Sex

Three studies were designed to investigate factors that may contribute to gay men's decisions to have unprotected anal intercourse. The studies looked at young gay men in Melbourne (up to 21 years old), older gay men in Melbourne (most of whom were between 20 and 39 years old), and two samples of older gay men in Sydney (most of whom were between 20 and 39 years old). Researchers recruited subjects at gay venues, most notably bars, discos, and sex clubs, but also at medical practices and gay organizations. Each of the samples represented a well-educated population: among the older participants, more than half had some post-secondary education and a large proportion were managers, professionals, or paraprofessionals.

Researchers collected data from the younger men through interviews and from the older men through self-administered questionnaires. In the main part of each study, subjects were asked to recall in great detail one occasion during which they had engaged in unprotected anal intercourse in the previous year or previous six months. It proved astonishingly easy to find men who had engaged in unprotected anal intercourse: over the three studies, 734 men acknowledged the practice. Of these men, 40 percent had had unprotected sex within the preceding month.

Could these men just have been practicing what has been called "negotiated" safety? That is, might they have engaged in unprotected anal intercourse only with men with whom they were in a monogamous relationship—or at least monogamous with respect to unprotected anal intercourse—and whom they knew had the same antibody status as they did? The data suggests that negotiated safety was not a factor.

Subjects reported three categories of partner: lover, casual but not anonymous partner, and anonymous partner [see table on page 3]. In each study, the majority—and in two samples, almost two-thirds—of these encounters had been with a casual partner. Indeed, in three of the samples, one-quarter of the encounters had been with a casual partner. Among the subsample of infected men in the Sydney study, the proportion with an anonymous partner was more than one-third. Even where the partner was a lover, the relationship was often not a long-standing one. And regardless of partner type, many men did not know their partners' serostatus. For example, only 12 percent of the young gay men in the
Editorial: Then and Now
Robert Marks, Editor

It came as no surprise to me—or, I dare say, to others in the audience—when Ron Gold declared at the International Conference on Biopsychosocial Aspects of HIV Infection that HIV prevention efforts were failing many gay men. The paradigm that had once been so effective in alerting the gay community to HIV-related risk has endured many criticisms during the past five years, but few have been expressed as forcefully as Gold’s.

The articles in this month’s issue of FOCUS derive themselves from Gold’s speech, notable for its persuasive reconsideration of prevention ideals that many of us have taken for granted: the existence of a safe sex culture, the importance of links to the community, and the efficacy of information campaigns. When Michael Helquist, the Founding Editor of FOCUS and our Editorial Advisor, reviewed Gold’s manuscript, however, he was concerned that the article insufficiently acknowledged the complexity of the population targeted by prevention efforts.

Helquist questioned two assumptions that he saw underlying Gold’s thesis. First, he said, the urban gay community is not monolithic and the response to prevention efforts is not uniform. Second, he suggested that, if this is true, one cannot assume that there has been an evolution in this response from “then”—the early days of the epidemic—to “now.” Helquist observed that there had been many “generations” of gay men who had passed through the epidemic—evolving from neophytes to veterans—and that the “information and exhortation” approaches that Gold condemned, when well-designed, continue to raise consciousness and yield behavior change among those who are new to the urban community or were newly out as gay.

Helquist’s words reminded me that this epidemic is amazing in its ability to regenerate itself. Just when you think everyone from here to eternity must know about safer sex, you realize that most of us listen with only half an ear to public health warnings. It is not until a person becomes a member of “a high-risk group”—an appropriately discredited concept that nonetheless retains a powerful cachet—that risk begins to mean something. “Then” and “now” are not 1985 and 1995; they are “my coming out” and “attending my fifth memorial service.”

Most frightening among Gold’s observations—based on admittedly preliminary data—is that many gay men participate in unprotected sex because of the social pressures and potential rejection inherent in being part of the urban gay community. His conclusion that gay men are no nicer to each other than are heterosexual men and women is no surprise. But its connection to unsafe sex does suggest a way of exploring relapse, developing new prevention strategies, and structuring therapy.

Melbourne sample had known that they and their partner were seroconcordant.

During 1993, a 16-week study sought to compare two intervention approaches.4 The recruitment criterion for this study was more specific than it had been in the earlier studies: in order to eliminate men who were practicing negotiated safety, subjects were men who had engaged in unprotected anal intercourse in the preceding six months and in doing so had broken their own safe sex rules.

Of the 700 men approached during recruitment, more than one-quarter said that they met the criteria for the study and 138 agreed to participate. One-third had engaged in unprotected anal intercourse with only one partner in the last six months; one-third had done so with two partners; and one-third with more than two. At the end of the 16 weeks, 109 men remained in the study. Of the 138 men who participated for even a short period, 64 percent “slipped up” again at least once during the study period.

All these studies targetted men who had engaged in unprotected anal intercourse. Currently, we are conducting some studies in which any gay man can participate. The aim of this work is to investigate whether it will be possible to adapt some of the techniques used in cognitive psychology to study gay men’s thinking about HIV infection. In the first sample, we recruited 79 men from a popular gay bar in Melbourne. Half had engaged in unprotected anal intercourse in the preceding six months; one-quarter had done so with more than one partner in that period. The second sample comprised 96 men, recruited from the same and another gay bar: 46 percent had engaged in unprotected anal intercourse during the preceding six months, and 18 percent had done so with more than one partner.

The Dangers of Mythology

Educational materials for the gay community often claim that there is a safe sex culture. These findings suggest that, while many gay men may successfully maintain safe sex regimens or practice negotiated
safety, in a substantial proportion of the gay community, there is not a safe sex culture. At best, there may be an “occasional slip-up culture.”

For example, one of the most visually attractive sets of posters produced for gay men in Australia has captions such as "Some of us are in love, some of us are in lust. All of us fuck with condoms—every time!" and "Some of us have HIV, some of us don’t. All of us fuck with condoms—every time!" We put out this sort of message because we assume that if people believe there is a strong peer norm for safe sex, they will comply with that norm.

But asserting that we have a safe sex culture may make it very difficult for gay men who slip up to admit this and discuss it with friends who might provide emotional support and guidance. There was evidence of this when we recruited for our studies. Time and again I would present my spiel to a group of friends in a bar, to be solemnly told by each of them that, no, they had not engaged in unprotected anal sex. And time and again these same men would later seek me out privately, to tell me that, yes, they had slipped up, but couldn’t admit it in front of their friends. As Walt Odets noted: AIDS education has had the effect of putting the gay man who does not maintain safe sex back into the closet.

I am even more concerned about the conclusions gay men who slip up may draw about themselves. For if everyone else is practicing safe sex, but I am slipping up, then there must be something wrong with me; I must be bad or deficient in some way. Social psychological research suggests that people find it much harder to recover from a lapse into undesirable behavior if they explain their lapse in this sort of way. The message that all gay men are maintaining safe sex may lead a gay man who does not do so to explain his behavior precisely in the way that is least likely to help him change that behavior.

Most important of all, I fear the effect of the claim that gay men have a safe sex culture on those who are responsible for devising, funding, and implementing HIV education for gay men. Educators and planners face a strong temptation to accept this claim unquestioningly, as a sort of received truth. The result has been an unjustified and worrying complacency.

**Efficacy of HIV Education**

The assertion that there is a safe sex culture among gay men has quite naturally led to the further claim that current HIV education for gay men is effective. The trouble is, no one actually bothers to test whether this is true. Over the past decade of HIV education in Australia, no study has investigated, for example, whether the posters, pamphlets, and videos used do what they are supposed to do, that is, help gay men to adopt and maintain safe sex. There is “evaluation” of educational campaigns, but it covers merely superficial factors—how many gay men have seen the posters, how many can recognize them later, how many like them. While these are crucial factors, they do not tell us whether the materials work to change behavior. As far as I know, Australia is not alone in this failing; there is a similar dearth of fundamental evaluation research throughout the world.

Indeed, there are grounds for doubting the efficacy of current HIV education materials. The content of these materials—combining information about risk behaviors and exhortations to have safe sex—has remained largely unchanged since the start of the epidemic. This “information and exhortation” approach was probably successful in the early days of the epidemic, and this success may have been due to the fact that it provided new information and brought home the magnitude of the threat. By now, however, knowledge about which behaviors are high-risk is very common among gay men. Further, it seems quite possible that gay men have become habituated to exhortations to have safe sex.

Our intervention study was designed to investigate an alternative approach to HIV education. Earlier we had found that at the time gay men make the decision to engage in unprotected anal intercourse, they generally try to justify this decision to themselves.

**Correction**

Due to a production error, a line of text is missing on page 5 of the December 1994 issue of *FOCUS*. The final sentence of "An Overview of the Literature," should read: "It is a clearly informative text for scientifically minded readers who seek a broad outline."
using various arguments to "give themselves permission" to have unsafe sex. How might HIV education target these self-justifications? The study hypothesized that many of the self-justifications represent thinking that only occurs during "the heat of the moment," thinking that is unique to actual sexual encounters. It posited that it might be possible to counter such self-justifications by getting gay men to reflect on and evaluate, in the cold light of day, the thinking that they employ when they are having sex.

Study participants kept a sexual diary for 16 weeks, filling out a standardized diary page as soon as possible after each sexual encounter and sending in completed pages at the end of each week. After four weeks, researchers assigned each man to one of three groups: the control, standard, or self-justifications groups. The control group received no educational intervention at all throughout the study.

At the end of Week 4 and Week 8, researchers sent participants in the standard group a set of HIV education posters designed for gay men and unfamiliar to this study population. Researchers asked the men to consider the posters in detail—rating each in terms of how eye-catching it was, and how effective it was at getting across the safe sex message to them—and justifying their judgments.

At the end of Week 4 and Week 8, researchers sent participants in the self-justifications group a questionnaire asking them to recall, as vividly as possible, a sexual encounter in which they had engaged in unprotected anal intercourse. The questionnaire included a list of possible self-justifications. It asked participants to indicate: the extent to which they had considered each of these at the moment they decided to have unprotected anal intercourse, the self-justifications that had been most strongly present in their minds, how reasonable each of these justifications seemed to them now, and explanations for these responses. Thus the process required the men to recall the thinking they had employed in the heat of the encounter and to reflect upon it in the cold light of day.

The three groups did not differ in the percentage who slipped up at least once during the post-intervention period. They did differ, however, in the percentage who slipped up more than once: 42 percent for the control group; 41 percent for the standard group; and 17 percent for the self-justifications group. Yet the groups did not differ in terms of the average number of sexual encounters during this period.

The comparison between the control group and the standard group is consistent with the hypothesis that "information and exhortation" materials, no matter how well-designed, are no longer effective. The comparison between the control group and the self-justifications group was more encouraging. It appears that, while getting gay men to reflect on and evaluate the thinking that they employ during sexual encounters does not eliminate all slip-ups, it does help to prevent repeated slip-ups. It seems that while this type of education is effective, its effect is delayed until the next slip-up has occurred. Presumably, their first post-intervention slip-up provoked and disturbed the men; their perception that they had "done it yet again" focused their minds on the problem. At that point, they began to absorb the lessons of the intervention.

**Conclusion**

This article presents some unpalatable findings: among large numbers of gay men, there is no safe sex culture; and the "information and exhortation" approach to HIV education is ineffective at changing behavior. Despite our discomfort with these facts, we must acknowledge them. If we do not, we will pay for it with the lives of gay men.

**Clearinghouse: Prevention – Gay Men**

**References**


Gay Community Links and Safety

Ron S. Gold, D Phil

There are good reasons for hypothesizing that having contact with the gay community should assist gay men to maintain safe sex. First, proximity to the community equals proximity to peer norms for safe sex. Second, gay community publications present what is perhaps the most accurate information about HIV disease to non-specialists. Third, support from gay social networks should help in dealing with the negative mood states or lack of self-esteem that may lead to unsafe practices. Finally, having first-hand experience of the epidemic should make the threat of the epidemic more vivid.

But, while it is clear that links with the gay community can often be beneficial, overstating these benefits without acknowledging potential limitations can add to the complacency regarding HIV prevention among gay men.

Australian Studies

Four Australian studies highlight the problem [see "Rethinking HIV Education for Gay Men," page 1, for a fuller description of these studies]. The samples from these studies consisted of men who had engaged in widespread unprotected anal intercourse, but who were in no way isolated from the gay community. For example, in an intervention study of 138 men [see page 2 for a fuller description], 46 percent had, or had once been, members of organized gay groups; 67 percent said that of their four closest friends, at least three were gay; and 57 percent reported that they read the gay press at least once a week.

Participants in this study had considerable experience of the epidemic: 83 percent had at least one friend or acquaintance who was HIV-infected, 63 percent knew someone with full-blown AIDS, and 51 percent had known someone who had died. While these men had strong links with the community, they had all broken their safe sex rules by having unprotected anal intercourse within the six months prior to the study.

Furthermore, in two of the studies, researchers found low, but statistically significant, positive correlations between unprotected anal intercourse and links to the gay community. In a study of young gay men, the number of different partners with whom participants had had unprotected anal intercourse over the preceding year was positively related to the proportion of the men’s closest friends who were gay; the frequency with which the men read the gay press; and the number of men they knew who were living with HIV disease or had died. The results for the intervention study mentioned above followed a similar pattern.

These results may differ from those obtained by other researchers because there were some notable differences in the samples. In the Australian studies, researchers targeted gay men who still engaged in unprotected anal intercourse. Most other studies, by contrast, have recruited gay men without restriction, presumably including many men who found it easier to stick to safe sex practices.

These findings suggest that contact with the gay community probably plays a different role for different men. For those who already have a strong orientation towards safe sex, links with the gay com-


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See also references cited in articles in this issue.
The starting point for a discussion of the second area is an analysis, undertaken in three of the Australian studies, that examined the growth of desire specifically for unprotected anal intercourse during an unsafe encounter. In general, the more distant the personal relationship between the two sexual partners—the further from being a lover and the closer to being an anonymous partner—the earlier there had been a desire specifically for unprotected anal intercourse. (This pattern was broken by young gay men having sex with anonymous partners: in this group, the desire for unprotected anal intercourse was almost as common as it was among young gay men having sex with lovers.)

What was the source of this anomaly? The analysis eliminated some obvious possibilities: these men had not been particularly intoxicated or stoned, nor had they been unusually sexually aroused. What distinguished this group was more complex: at the start of the evening, these men had been in a particularly bad mood—for example, depressed, bored, or stressed. Unsafe sex had been what is often referred to as “angry fucking.”

The results did not reveal why these men had been in a bad mood. But later, while I was recruiting for other studies, I occasionally asked young gay men what sorts of things put them in a really bad mood. I did this in a very informal, unsystematic way, but the results were disturbing. The men complained about a variety of issues (difficulties with parents, homophobia, unemployment), but dismissed most as routine hassles, handled, if necessary, simply by ignoring them.

By contrast, they reserved their real vehemence for descriptions of their treatment at the hands of other gay men. If one did not have the right “look”—the cuteness, the straight white teeth, the firm, gym-toned body, even the right clothes—the consequences could be awful.

Conclusion

This is a side of the story that we usually do not hear. The official version is that the gay world is full of caring and emotional support. It is unpleasant to think that in many cases some of the dynamics of the gay world may contribute to the depression and desperation that provoke unsafe sex. We need to face up to the possibility that our view of the gay community is too benign and simplistic, that how gay men relate to one another may often be part of the problem, rather than part of the solution.
Recent Reports

Maintaining Safe Sex


Three recent reports, all published in the journal *AIDS*, debate whether absolute safety is a reasonable prevention goal and an effective prevention message. According to an Australian study, which sets the parameters of the debate, the practice of “negotiated safety,” in which sexual partners with the same serostatus engage in intercourse without a condom, has gained popularity. As a result, unprotected anal intercourse need not constitute a relapse into unsafe sex.

A 1986-1987 survey of men who have sex with men revealed that several safe sex strategies—including using condoms, avoiding anal intercourse, foregoing intercourse with casual partners, and remaining monogamous—were taking hold within the community. In 1991, 31 percent of the original sample of 535 responded to a follow-up telephone survey that showed an overall maintenance of safe sexual practice and an increase in behaviors associated with negotiated safety, particularly among couples in which both partners were seronegative. The proportion of men who engaged in anal intercourse without condoms decreased, particularly with casual partners, and 79 percent of the men in the 1991 sample reported a “clear agreement” on sexual practice within their regular relationships.

In response to this article, Peter M. Davies states that the unreasonable standards of risk elimination strategies are inevitably self-defeating and emphasizes the need for reasonable HIV prevention goals. The implication of the Australian study—that negotiated safety constitutes “safer” behavior in most cases—supports the theory that human behavior will tend toward risk minimization rather than risk elimination. Defining safer sex in more attainable and sustainable terms like negotiated safety—rather than as absolutes of “safe” and “unsafe”—is a more realistic way to approach HIV risk.

A second response to the Australian study by Maria Ekstrand and her colleagues states that the ultimate goal of safer sex strategies should be nothing less than elimination of future infection. Negotiated safety is inherently flawed because it relies on accurate knowledge and truthful communication of serostatus, and is therefore inherently risky; “negotiated danger” defines this approach more precisely. While relapse to unsafe behavior may be part of a normal human learning process, it should not be excused by HIV prevention efforts that aim at mere minimization of risk. In the long run, while risk elimination may be impossible, it is the only acceptable goal.

Prevention for Seronegative Men

Undifferentiated AIDS education programs—ostensibly serving both infected and uninfected gay men—alienate seronegative gay men and because of their generality, undermine primary prevention efforts, according to this critique of HIV prevention strategies.

The goal of primary prevention is to stop the spread of HIV to currently uninfected men. Existing education programs, however, combine primary prevention with secondary and tertiary prevention, which seek to control the clinical progression of HIV disease. These undifferentiated programs confuse identities between uninfected and infected men, exacerbating feelings that it is inevitable, even desirable, to contract HIV; overlook the distinct psychosocial issues of uninfected men; and disenfranchise uninfected men from the gay community that would otherwise serve to enforce safer sex through peer norms. This situation is particularly ironic because, while seronegative men are the only ones at risk for primary infection, they are left with the belief that their prevention needs are insignificant.

Prevention strategies designed in 1985 before the advent of effective HIV testing had to assume that all men were HIV infected. But the development of antibody testing did not deliver effective primary prevention; after 1985, prevention switched to secondary and tertiary modes,
fo\[11pt]cusing on those who were already HIV infected. Current prevention strategies include seronegative men only by implication and adopt seropositive men as spokespeople. A true primary prevention plan would single out seronegative men, advertise its efforts to keep men uninfected, and explicitly state the benefits of remaining uninfected.

**Predicting Preventive Behavior**


A comparative test of the information-motivation-behavioral skills (IMB) model shows that it successfully represents the determining factors of healthy behavior. The IMB model draws upon the strengths of several previous models—social-cognitive theory, the theory of reasoned action, the health belief model, and the AIDS-risk-reduction model—and specifies HIV-related behavioral determinants applicable to a variety of populations.

According to the IMB model, HIV prevention knowledge and motivation are the primary variables, factors that are translated through behavioral skills to action regarding sexual activity. These primary variables can act independently of behavioral skills. For example, when one is sufficiently motivated to avoid sexual activity, communication and negotiation skills need not enter the equation. The basis of the model, however, is that individuals possessing sufficient information, motivation, and behavior skills will behave predictably to prevent HIV transmission.

The IMB model was tested in two surveyed populations: gay men and heterosexual university students. The results confirmed the generalizability of the model across diverse risk populations.

**Perception and Inconsistency**


Despite intermittent condom use or reliance on monogamy as their only preventive measures, gay men in a small study perceived their behavior to be sufficient to eliminate HIV-related risk. These inaccurate perceptions appeared to result from dissonance-reducing techniques, which alter perceptions in response to psychological tension caused by the disparity between risk and behavior.

Forty-one self-identified homosexual men participated in one two-hour focus discussion group consisting of two to six participants. The majority of participants were middle-class Whites between the ages of 25 and 45.

Thirty-nine of the 41 men reported at least one instance of unprotected, risky sex since initiating condom use for the purpose of HIV risk reduction. More than half of these men offered explanations for why a particular instance of unsafe sex was not unsafe. Many were able to justify any unsafe behaviors after the fact. Of those involved in monogamous relationships, there was a tendency to rely on monogamy as the sole means of protection. In only one of these eight couples, however, had both partners been tested for HIV antibody. Twenty-six participants perceived risky behavior as consistent with their “safe” self-image, because it was not normal for them.

Participants also reported unreliable means of risk reduction. For example, 11 men used non-verbal clues to determine a partner’s risk level, five men relied on a single negative antibody test result as “proof” of their immunity to infection, and a few men reported adopting improved nutrition and positive attitude—rather than condoms—to prevent infection.

**Next Month**

Communities of color present particularly difficult prevention challenges to a culture whose strategies are often based on parochial experience. This is no truer than among the Latino and Hispanic subcultures of the United States. In the March issue of *FOCUS,* [Francisco J. González, MD](mailto:francisco.gonzalez@ucsf.edu), a resident in psychiatry at the University of California San Francisco, looks at the cultural ambiguity experienced by Latino men who have sex with men and the counseling issues that this raises.

Also in the March issue, [Cynthia A. Gómez, PhD](mailto:cynthia.gomez@ucsf.edu), a researcher at the UCSF Center for AIDS Prevention Studies, reports on a study of the factors that affect sexual relationships between Latino men and women. She explores sexual socialization, interpersonal power, and cultural gender norms.
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